

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (73)

CERTIFICATE OF DEATH

08296

Reg. Dist. No. 282

1. PLACE OF DEATH:

County St. Mary's CountyCity or town near Oakville, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Unknown County

City or town (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

AMICK, Joseph Carnes

3. (b) Social Security Number

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

Male

White

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7-6-188. AGE: Years Months Days If less than one day
28 0 29 hrs. min.9. Birthplace Indiana
(Town, county, and state)10. Usual occupation U. S. Navy

11. Industry or business

12. Name Unknown

13. Birthplace

14. Maiden name Unknown

15. Birthplace

16. Informant U. S. NavyAddress Patuxent River Md.17. Transportation 8/7/46
(Burial, cremation, or removal. Which?) Date thereof (month) (day) (year)Cemetery or crematory Removal toLocation Cincinnati, Ohio18. Funeral director Longbottom, MarylandAddress Longbottom, Maryland19. 8/7/46 Caution
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 5 August 19 46 at 3:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

not attended 19 to 19and that I last saw him not attended 19Immediate cause of death Injuries, Multiple, Extreme

DURATION

Due to Airplane crash

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide accident Date of 5 Aug. 46Where did injury occur? near Oakville, Maryland
(City or town) (County) (State)Injured at home, farm, industry, public place (where?) airplane crashMeans of injury airplane crash Injured at work? yes

23. SIGNATURE

J. Warren
J. WARREN, Comdr. USNR (MC)
M. D. or otherAddress US NAS. Patuxent River, Md. Date signed 7 Aug. 46

RECEIVED
AUG 9 1946
BUREAU V. &

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 168

CERTIFICATE OF DEATH

Reg. Dist. No. 2820

1. PLACE OF DEATH:

County St. Mary's
 City or town (Burial) Leonardtown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County St. Mary's
 City or town Leonardtown (Rural)
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 6
 (If rural, give LOCATION)
 2. (a) If veteran, name war 6

3. (a) FULL NAME

Robert Louis Blackiston Cooper

3. (b) Social Security Number

6

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

male colored single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) February 17, 1946

8. AGE: Years Months Days If less than one day

- 6 - - hrs. min.

9. Birthplace Maryland
(Town, county, and state)10. Usual occupation none

11. Industry or business

12. Name James L. Cooper13. Birthplace Maryland14. Maiden name Alice C. Blackiston15. Birthplace Maryland16. Informant Alice C. BlackistonAddress Leonardtown, Md.17. Burial Date thereof 12/1/46
(Burial, cremation, or removal. Which) (month) (day) (year)Cemetery or crematory St. AlphonsusLocation Leonardtown18. Funeral director G. B. RobinsonAddress Leonardtown, Md.19. 12/1/46 Causes
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 17, 1946 at 8:46 PM21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1946 to 1946and that I last saw him alive on 1946

Immediate cause of death

Due to fractured of kneesDue to heart disease inDue to artery

Other conditions

Major findings of operations

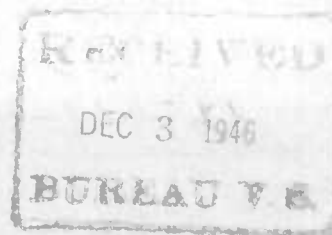
Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? Leonardtown St. Mary's Md.
(City or town) (County) (State)Injured at home, farm, industry, public place (where?) HomeMeans of injury from a well Injured at work?23. SIGNATURE Paul H. CameronAddress Leonardtown Date signed 12/1/46



1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 773

CERTIFICATE OF DEATH

08297

Reg. Dist. No.

1. PLACE OF DEATH:

County.....St. Mary's
City or town.....Seaside
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?.....13 yrs
Hospital, institution, or street address where death occurred:
Seaside Board Co. road leading to
Colton St.
How long in hospital or institution?.....Colton St.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... County.....
City or town.....
(If outside city or town limits, write RURAL and give nearest town)
Street No.....
(If rural, give LOCATION)
2.(a) If veteran, name war.....

3. (a) FULL NAME

4. Sex.....M 5. Color or race.....W. 6.(a) Single, married, widowed, or divorced.....—

6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)..... 8.(c) If alive, give age..... years

8. AGE: Years.....40 Months..... Days..... If less than one day..... hrs. min.

9. Birthplace.....Georgia
(Town, county, and state)

10. Usual occupation.....Gas station

11. Industry or business.....building houses & barns

12. Name.....not known

13. Birthplace.....—

14. Maiden name.....—

15. Birthplace.....—

16. Informant.....Thomas H. Lacey

Address.....Seaside Rd

17. Crematorium Date thereof.....Aug 12 46
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory.....County Cemetery & Farm

Location.....Leonardtown, Md

18. Funeral director.....Wm. R. Dunnington

Address.....Leonardtown Rd

19. 8/12 46 Causey
(Date rec'd by registrar) Registrar

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH.....Aug 4 1946 at.....109 M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from.....from time of death on Aug 4 1946

and that I last saw.....— alive on..... 19.....

Immediate cause of death.....acute tuberculation of heart

Due to.....acute alcoholism

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE.....H. J. Greenwell M. D. or other

Address..... Date signed.....

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

UNITED STATES DEPARTMENT OF JUSTICE

OFFICE OF THE ATTORNEY GENERAL

RECEIVED
AUG 14 1946
BUREAU V S

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 284

1. PLACE OF DEATH:

County St. Mary'sCity or town (Rural) Mechanicville, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County St. Mary'sCity or town (Rural) Mechanicville, Md.
(If outside city or town limits, write RURAL and give nearest town)Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Mary Catherine Curtis

3. (b) Social Security Number

4. Sex

Female

5. Color or race

Negro

6.(a) Single, married, widowed, or divorced

Married

6.(b) Name of husband or wife

Bernard Curtis

7. Birth date of deceased (mo., day, yr.)

Sept. 16, 1909

6.(c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

361112

hrs.

min.

9. Birthplace

St. Mary's County, Maryland
(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden name

15. Birthplace

16. Informant

Address

17.

Burial

Date thereof

(Burial, cremation, or removal. Which?)

Aug 30, 1946
(month) (day) (year)

Cemetery or crematory

St. Joseph's

Location

Maryland

18. Funeral director

E. J. Jones, Inc.

Address

Mechanicville, Md.19. Aug 29, 1946

(Date rec'd by registrar)

Eleanor S. Carter

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 28, 1946 at 2:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Oct 45 to Aug 46and that I last saw him alive on Aug 28, 46

Immediate cause of death

Carcinoma Uteri

DURATION

14 mo

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Radiation & X-ray treatment

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Alyson C. Wild

M. D. or other

Address

Chesapeake, Md.

Date signed

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1946

ST. V. C.

AUG 30 1946

BUREAU V. C.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore *B10*

CERTIFICATE OF DEATH

Reg. Dist. No. *08299* *282*

1. PLACE OF DEATH:

County *St Marys*
 City or town *Leonardtown Md*
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? *20 years*
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State *Maryland* County *St Marys*
 City or town *Leonardtown*
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)

2.(a) If veteran, name war _____

3.(a) FULL NAME

St. Francis Dent, G. Francis

3.(b) Social Security Number

4. Sex *male* 5. Color or race *white* 6.(a) Single, married, widowed, or divorced *married*6.(b) Name of husband or wife *Frances Hatfield Dent*6.(c) If alive, give age *50* years7. Birth date of deceased (mo., day, yr.) *April 7 - 1870*8. AGE: *76* Years *4* Months *19* Days If less than one day _____ hrs. _____ min.9. Birthplace *St Marys Maryland*
(Town, county, and state)10. Usual occupation *Retired*

11. Industry or business

FATHER 12. Name *Charles Dent*
13. Birthplace *St Marys Co*MOTHER 14. Maiden name *Hartmann*
15. Birthplace *St Marys Co*16. Informant *Dr. Walter D. Wise*
Address *420 St Paul St Baltimore Md*17. Burial, cremation, or removal. Which? *Burial* Date thereof *Aug 28 1946*
(month) (day) (year)Cemetery or crematory *St Andrews*
Location *near Leonardtown Md*18. Funeral director *W C. Mattingly Sons*
Address *Leonardtown Md*19. *8/28 46* Registrar *Caecilia*
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH *Aug 26* 19 *46*, at *5:30 P.M.*21. I CERTIFY that death occurred on the date above stated; that I attended deceased from *August 15* 19 *46*, to *Aug. 26* 19 *46*, and that I last saw him alive on *August 26* 19 *46*.

Immediate cause of death _____ DURATION

Acute Heart Failure *1 day*Due to *Hypertension and Hyper-*
tensive Heart Disease. } *Several*
 } *years.*Other conditions *Chronic nephritis*
with uremia.
(Include pregnancy within 3 months of death)

Major findings of operations. _____ Date of op. _____

Autopsy results. _____
PHYSICIAN: Please underline the cause to which death should be charged statistically.22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE *Robert F. Fuchs M.D.*
Address *Leonardtown, Md* Date signed *8/27/46*

RECEIVED

AUG 29 1946

BUREAU V R

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

08300

Reg. Dist. No. 284

1. PLACE OF DEATH:

County St. Marys
 City or town Rt. 234 2 mi. North of Chaptico, Md.
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State New York County _____
 City or town New York City
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 50 - East 10th St.
 (If rural, give LOCATION) ✓

2.(a) If veteran, name war

3. (a) FULL NAME

Bernard John Flynn

3. (b) Social Security Number

4. Sex male 5. Color or race white 6. (a) Single, married, widowed, or divorced married
 8. (b) Name of husband or wife Dorothy V.L. Flynn
 6. (c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) July 1881 ?
 8. AGE: Years 65 ? Months _____ Days _____ If less than one day Approximately hrs. _____ min.

9. Birthplace New Orleans, La.
 (Town, county, and state)

10. Usual occupation

11. Industry or business Business Consultant

12. Name Unknown
 13. Birthplace Unknown

14. Maiden name Unknown
 15. Birthplace Unknown

16. Informant Fred V. Flynn
 Address 1514 17th St. N.W. Wash. D.C.

17. Burial Date thereof 8/24/46
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Mt. Olivet
 Location Washington, D.C.

18. Funeral director P.B. Robinson
 Address Leonardtown, Maryland.

19. 8/22 19 46 Canalier
 (Write rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 20 19 46 at 6:30 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from on Aug 20 19 46 to _____ 19 _____
 and that I last saw _____ alive on _____ 19 _____

Immediate cause of death Cerebral injuries DURATION _____
and crushed thorax
 Due to _____
 Due to Automobile accident

Other conditions _____
 (Include pregnancy within 3 months of death)

Major findings of operations _____
 Date of op. _____

Autopsy results _____
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide Accident Date of Aug 20-1946
 Where did injury occur? State Highway 249 near (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?) Highway
 Means of injury Automobile Injured at work? No

23. SIGNATURE W. Greenwell M. D. or other _____
 Address Leonardtown, Md. Date signed 8-21-46

RECEIVED

AUG 24 1946

BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 178

08301

CERTIFICATE OF DEATH

Reg. Dist. No. 287

1. PLACE OF DEATH:

County St. Mary's CountyCity or town near Oakville, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State California County Los Angeles Co.City or town Shirland
(If outside city or town limits, write RURAL and give nearest town)Street No. 10351 McVane Avenue

(If rural, give LOCATION)

2.(a) If veteran, name war

W. W. II.

3. (a) FULL NAME

FLYNN, Patrick Thomas

3. (b) Social Security Number

470-09-6970

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

married6. (b) Name of husband or wife Alberta Helen Flynn

8. (c) If alive, give age _____ years

7. Birth date of

deceased (mo., day, yr.)

10-26-18

8. AGE:

Years

Months

Days

If less than one day

2799

_____ hrs.

_____ min.

9. Birthplace

Minnesota - Duluth

(Town, county, and state)

10. Usual occupation

U. S. Navy

11. Industry or business

Aeronautical Engineer

MOTHER FATHER

12. Name

Unknown Thomas Flynn

13. Birthplace

Duluth, Minnesota

14. Maiden name

Josephine Bolot

15. Birthplace

Duluth, Minnesota

16. Informant

U. S. Navy

Address

Patuxent River, Md.

17. Burial

(Burial, cremation, or removal, Which?)

Date thereof

8/8/46
(month) (day) (year)

Cemetery or crematory

Arlington National

Location

Arlington, Virginia

18. Funeral director

Lea, Patuxent River, Md.

Address

Lea, Patuxent River, Md.

19.

(Date rec'd by registrar)

8/846Counselor

Registrar

MEDICAL CERTIFICATION

2D. DATE OF DEATH Aug 5 1946, at _____ M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
not attended 19____, to 19____and that I last saw him _____ alive on not attended 19____Immediate cause of death Multiple Injuries,
Extreme

DURATION

Due to Airplane crash

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide accident Date of 5 Aug. 1946Where did injury occur? near Oakville, Maryland
(City or town) (County) (State)Injured at home, farm, industry, public place (where?) airplane crashMeans of injury airplane crash Injured at work? yes

23. SIGNATURE

J. Warren
J. WARREN Comdr. (MC) USNR
M. D. or otherAddress US NAS, Patuxent River, Md. Date signed 7 Aug. 46

MARGIN RESERVED FOR BINDING

I

VS A15 9.45.15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

AUG 9 1946

BUREAU V S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (43-21)

08302

CERTIFICATE OF DEATH

Reg. Dist. No. 287

1. PLACE OF DEATH:
County St. Mary's County
City or town Great Mills, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Dispensary, NAS, Patuxent River, Md.
How long in hospital or institution? about three hours.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Pennsylvania County Kearney
City or town Kearney
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2(a) If veteran, name war

3. (a) FULL NAME
GIFFIN, Herbert Daniel

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Lillian Giffin

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11-16-17

8. AGE: Years 28 Months 8 Days 19 If less than one day hrs. min.

9. Birthplace Kearney, Pennsylvania
(Town, county, and state)

10. Usual occupation Aviation Metalsmith

11. Industry or business U.S. Navy

12. Name Unknown

13. Birthplace

14. Maiden name Unknown

15. Birthplace

16. Informant U.S. Navy

Address Patuxent River Md.

17. Date thereof 8/9/46
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory removal to

Location Warrington, Virginia

18. Funeral director Robinson

Address Patuxent River, Md.

19. 8/8 46 Cavalier

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 5 August 19 46, at 2:25 P.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from on
5 August 19 46 to 19

and that I last saw him alive on 5 August 19 46

Immediate cause of death Fracture, Compound,
Skull, left Parietal Bone

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Fracture, compound, skull, left parietal

Autopsy results bone, intracranial hemorrhage

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide accident Date of 5 Aug. 46

Where did injury occur? Great Mills, St. Mary's, Md.
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Public place

Means of Injury struck on head with injured at work? no

Paul Vaughan

23. SIGNATURE PAUL VAUGHAN, Capt. (MC) USN

US NAS, Patuxent River, Md. or other

Address Date signed 7 Aug. 46

MARGIN RESERVED FOR BINDING

I

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

AUG 10 1946

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 582

CERTIFICATE OF DEATH

Reg. Dist. No. 08303 28

1. PLACE OF DEATH:

County St. Mary's
 City or town Leonardtown, Md.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?
 Hospital, institution, or street address where death occurred:
St. Mary's Hospital
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County St. Mary's
 City or town California, Md.
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. C
 (If rural, give LOCATION)
 2.(a) If veteran, name war C

3. (a) FULL NAME

William H. Goerke

3. (b) Social Security Number

C

4. Sex male 5. Color or race white 6. (a) Single, married, widowed, or divorced single
 6. (b) Name of husband or wife
 6. (c) If alive, give age 1890? years
 7. Birth date of deceased (mo., day, yr.)
 8. AGE: Years 56? Months Days If less than one day
 hrs. min.

9. Birthplace Holland
 (Town, county, and state)
 10. Usual occupation retired
 11. Industry or business Cook
 12. Name Unknown
 13. Birthplace
 14. Maiden name Unknown
 15. Birthplace

16. Informant Leslie C. Wilkins
 Address California, Md.
 17. Burial Date thereof 8/28/46
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory St. Johns
 Location Hollywood, Md.
 18. Funeral director J.B. Robinson
 Address Leonardtown, Md.
 19. 8/27/46 Critcher
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 26, 1946 at 3:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
Sept. 15, 1945 to Aug. 26, 1946
 and that I last saw him alive on Aug. 25, 1946

Immediate cause of death

Carcinoma of Kidney
with generalized metastasis

DURATION

18 mos.

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

Dr. H. Patrick M.D.
Beavron, Md. M. D. or other
 Address Date signed 8-27-46

AMERICAN LEGION

TABLE OF CONTENTS

RECEIVED
AUG 29 1946
BUREAU V 8

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 92-d

CERTIFICATE OF DEATH

08304

Reg. Dist. No. 282

1. PLACE OF DEATH:

County St. Mary's
 City or town Campton
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 12 yrs.
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

John W. Gordon

3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

male Colored married

6. (b) Name of husband or wife

Ida Gordon

7. Birth date of deceased (mo., day, yr.)

Feb. 18, 1883

8. AGE: Years 63 Months 5 Days 28 It less than one day

9. Birthplace

Maryland

10. Usual occupation

Farmer

11. Industry or business

George Gordon

12. Name

Maryland

13. Birthplace

Hagerstown

14. Maiden name

15. Birthplace

16. Informant

Address

17. Burial

Date thereof

Cemetery or crematory

Location

18. Funeral director

Address

19. Date rec'd by registrar

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants, give residence of mother)
 State Maryland County St. Mary's
 City or town Campton
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 1
 (If rural, give LOCATION)
 2. (a) If veteran, name war 1

MEDICAL CERTIFICATION

20. DATE OF DEATH August 15, 1946, at 9:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw him on August 15, 1946

Immediate cause of death

DURATION

Probable Acute Cardiac Disturbance

Due to

Chronic Endocarditis

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur?

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

Address

Date signed

RECEIVED
AUG 17 1946
BUREAU V S.

Guernsey
ARTESIAN LEDGER

SAC CONTENT

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (17-2)

CERTIFICATE OF DEATH

08305
Reg. Dist. No. 282

1. PLACE OF DEATH:

County St. Mary's
City or town Chaptice, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life time
Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County St. Mary's
City or town Chaptice
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war.

3. (a) FULL NAME

Samuel Bond Hayden

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Widowed

6. (b) Name of husband or wife.

7. Birth date of deceased (mo., day, yr.) May 9, 1863 6.(c) If alive, give age years

8. AGE: Years 83 Months 3 Days 18 If less than one day hrs. min.

9. Birthplace Chaptice, St. Mary's County, Md.
(Town, county, and state)

10. Usual occupation Farming

11. Industry or business

12. Name George Hayden

13. Birthplace Maryland

14. Maiden name Elizabeth Bond

15. Birthplace Maryland

16. Informant Mr. Alfred Davis

Address Chaptice, Md.

17. Burial Date thereof 8/30/46
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Christ Church Chaptice Md.

Location Chaptice Md.

18. Funeral director Rose E. Welch

Address Chaptice Md.

19. 8/28 46 Cavalier
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

2D. DATE OF DEATH Aug. 27 1946, at 5:45 A.M.

2f. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug. 20 1946, to Aug. 27 1946, and that I last saw him alive on Aug. 26 1946

Immediate cause of death

Coronary Lesion
Due to Old age

Due to Cardio-renal Vas. disease

Other conditions Chronic Myocarditis

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Alfred Davis M. D. or other

Address Chaptice Md. Date signed 8/28/46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
AUG 31 1946
BUREAU V S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 465

CERTIFICATE OF DEATH

Reg. Dist. No. 281

1. PLACE OF DEATH:

County St. Marys
 City or town Rural Piney Point
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County St. Mary's
 City or town Rural Piney Point
 (If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Karl E. Krumke

3. (b) Social Security Number

4. Sex male 5. Color or race white 6. (a) Single, married, widowed, or divorced married
 6. (b) Name of husband or wife Ida M. Krumke
 6. (c) If alive, give age 53 years
 7. Birth date of deceased (mo., day, yr.) Dec. 8 1892

8. AGE: Years 53 Months 8 Days 20 If less than one day
 hrs. min.

9. Birthplace Wash. D.C.
 (Town, county, and state)

10. Usual occupation Tool maker (retired)

11. Industry or business

MOTHER FATHER
 12. Name Carl Krumke
 13. Birthplace Germany
 14. Maiden name Babette Ziegler
 15. Birthplace Germany

16. Informant Ida Krumke
 Address Piney Point Md

17. Burial Date thereof 8-30-46
 (Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Poplar Hill
 Location Valley Lee, Md

18. Funeral director E. L. Robinson
 Address Dameron, Md

19. 8-29-46 Registrar
 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 28 1946, at 11:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

1946 to Aug. 28 1946
 and that I last saw him alive on Aug. 28 1946

Immediate cause of death

Carcinoma of stomach

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

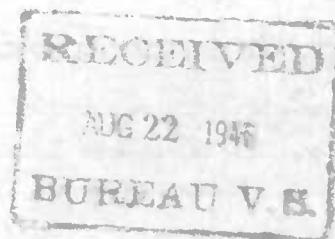
23. SIGNATURE P. J. Bean, M.D. M. D. or otherAddress Great Mills Md Date signed 8-29-46

RECEIVED
SEP 2 1946
BUREAU V.S.

CERTIFICATE OF DEATH

★ 08307
Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 77-2

08308

CERTIFICATE OF DEATH

★ Reg. Dist. No. 281

1. PLACE OF DEATH:

County St. Mary's
 City or town Great Mills (Rural)
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County St. Mary's
 City or town Rural, Great Mills
 (If outside city or town limits, write RURAL and give nearest town)

Street No. _____
 (If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

William Ryan Matthews

3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

married6. (b) Name of husband or wife Leona Matthews7. Birth date of deceased (mo., day, yr.) Oct. 2 1893

6. (c) If alive, give age _____ years

8. AGE: Years 52 Months 10 Days 16 It less than one day _____ hrs. _____ min.9. Birthplace Great Mills Md.
(Town, county, and state)10. Usual occupation Blacksmith

11. Industry or business

12. Name William Matthews13. Birthplace Great Mills Md.14. Maiden name Alice (Unknown)15. Birthplace Unknown16. Informant Joseph R. MatthewsAddress Great Mills Md.17. Burial Date thereof 8-21-46
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Holy FaceLocation Great Mills, Md.18. Funeral director Tom C. Mattingly Son'sAddress Leonardtown Md.19. 8-19- 1946 P. J. Beary Md.
(Date rec'd by registrar) (month) (day) (year) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August, 18 1946 at 8:15 P. M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug. 18 1946 to Aug 18 1946and that I last saw him alive on Aug 18 1946

Immediate cause of death _____

DURATION

Convulsions 4 hoursDue to Auto electrocution 1 month

Due to _____

Other conditions _____

(Include pregnancy within 8 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work?

23. SIGNATURE P. J. Beary Md. M. D. or otherAddress Great Mills, Md. Date signed 8-19-46

RECEIVED

AUG 21 1946

BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93d

CERTIFICATE OF DEATH

Reg. Dist. No. 282

08369

1. PLACE OF DEATH:

County St. Mary's
 City or town Lemondtown Md
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 2 1/2 years
 Hospital, institution, or street address where death occurred:

How long in hospital or institution? 1 hour

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County St. Mary's
 City or town Lemondtown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)

2. (a) If veteran, name war _____

3. (a) FULL NAME

Charles M. Ramos

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced married6. (b) Name of husband or wife Lola C. Ramos7. Birth date of deceased (mo., day, yr.) Oct-6-1900 6. (c) If alive, give age 41 years8. AGE: Years 46 Months 6 Days 6 If less than one day _____ hrs. _____ min.9. Birthplace Puerto Rico
(Town, county, and state)10. Usual occupation General Helper

11. Industry or business

12. Name Charles M. Ramos Sr13. Birthplace Puerto Rico14. Maiden name Marjorie Marie Ramos15. Birthplace Puerto Rico16. Informant Mrs. Lola C. RamosAddress Lemondtown Md17. Burial Date thereof Aug-14-1946
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory St. AloysiusLocation Lemondtown Md18. Funeral director W.C. Martin & SonsAddress Lemondtown Md19. 8/13 46 Cause
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 12 19 46 at 10:00 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 1944 to Aug 12-46and that I last saw him alive on Aug 12-46Immediate cause of death Chronic Thrombosis DURATION 4 hrsDue to Arterial Sclerosis 4 yrsDue to & Myocarditis Chronic 4 yrs

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Autopsy results _____ Date of op. _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE J.F. Greenwell M.D. M. D. or otherAddress Lemondtown Md Date signed Aug 12-46

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
AUG 15 1946
BUREAU V B.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 920

CERTIFICATE OF DEATH

Reg. Dist. No. 282

1. PLACE OF DEATH:
County St. Marys
City or town Leonardtown, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 7 days
Hospital, institution, or street address where death occurred:
How long in hospital or institution? 7 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Charles
City or town Fort Victoria
(If outside city or town limits, write RURAL and give nearest town)
Street No. _____
(If rural, give LOCATION)
2(a) If veteran, name war _____

3. (a) FULL NAME
Thomas D. Sanford

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced married
6. (b) Name of husband or wife Elma A. Sanford

7. Birth date of deceased (mo., day, yr.) Oct 17 1884 6. (c) If alive, give age 66 years

8. AGE: Years 59 Months 10 Days 1 If less than one day _____ hrs. _____ min.

9. Birthplace Spotsylvania Va
(Town, county, and state)

10. Usual occupation Farmer

11. Industry or business same

12. Name Lewisance Sanford

13. Birthplace Va.

14. Maiden name Georgia Baker

15. Birthplace Va.

16. Informant Mrs. Elma A. Sanford

Address Fort Victoria Charles Co Md

17. Burial Date thereof Aug 21 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Arlington Va

Location Fort Myer Va

18. Funeral director W C Hattaway Son

Address Leonardtown Md

19. 820 46 Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 18 1946 at 9:15 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from _____ to _____

and that I last saw him alive on August 18 1946

Immediate cause of death _____

Heart failure DURATION ca 6 weeks

Due to Arterio Sclerosis and Regurgitation

Due to Latent (Rheumatic Heart)

Other conditions _____

(Include pregnancy within 8 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Robert V. Fuchs M.D.

Address Leonardtown Md Date signed 9/19/46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
AUG 22 1946
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (97)

CERTIFICATE OF DEATH

08311

Reg. Dist. No. 282

1. PLACE OF DEATH:

County St. Mary's
City or town Quinal, California
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State md. County St. Mary's
City or town California, md.
(If outside city or town limits, write RURAL and give nearest town)
Street No. L
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME

John J. Somersville

3. (b) Social Security Number

4. Sex m 5. Color or race Colored 6. (a) Single, married, widowed, or divorced widowed

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) July 27, 1873 8. (c) If alive, give age, years

8. AGE: Years 73 Months 0 Days 25 If less than one day hrs. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual occupation retired

11. Industry or business

12. Name John Somersville

13. Birthplace Maryland

14. Maiden name Unknown

15. Birthplace

16. Informant Bernard J. Somersville

Address Hollywood Md.

17. Burial Burial Date thereof 8/23/46
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory St. Johns

Location Hollywood Md.

18. Funeral director J.B. Robinson

Address Leonardtown Md.

19. 8/22 46 Carroll
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 21 1946 9:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 15 1946 to Aug 21 1946
and that I last saw him alive on Aug. 21 1946

Immediate cause of death Heart Failure

Due to Hypertension DURATION 1 week

Due to Generalized Atherosclerosis 54 years

Other conditions Auricular Fibrillation 5 years

6 mo.

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Mr. H. Patrick M.D. M. D. or other

Address Beaumont Md. Date signed 8-22-46

MARGIN RESERVED FOR BINDING

VS A15 9.45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

ALPES ALPINE

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 173

CERTIFICATE OF DEATH

Reg. Dist. No. 282

1. PLACE OF DEATH:

County St. Mary's CountyCity or town near Oakville, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State _____ County _____

City or town U. S. Navy
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

STAFFORD, Peary Diebitsch

3. (b) Social Security Number

4. Sex _____ 5. Color or race _____ 6.(a) Single, married, widowed, or divorced _____

Male

White

Married

8.(b) Name of husband or wife Lois Waite Stafford7. Birth date of
deceased (mo., day, yr.)July 3, 1920

6.(c) If alive, give age _____ years

8. AGE: Years _____ Months _____ Days _____ If less than one day _____

2612

_____ hrs. _____ min.

9. Birthplace Portland, Maine
(Town, county, and state)10. Usual occupation Aviator,11. Industry or business U.S. NavyFATHER
MOTHER12. Name Unknown

13. Birthplace _____

14. Maiden name Unknown

15. Birthplace _____

16. Informant U. S. Navy

Address _____

17. Burial Date thereof 8/8/46
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory Arlington National
V.L. Speare Undertakers, Virginia

Location _____

18. Funeral director 1009 H. St., N.W.,Address Washington, D.C.19. 8/6 46
(Date rec'd by registrar)19. Caualtur
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 5 August 19 46, at 3:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

not attended 19 _____, to _____ 19 _____and that I last saw him _____ alive on _____ not attended 19 _____Immediate cause of death Injuries, Multiple,
Extreme

DURATION

Due to Airplane Crash

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide accident Date of 5 Aug. 1946Where did injury occur? near Oakville, Maryland
(City or town) (County) (State)Injured at home, farm, industry, public place (where?) airplane crashMeans of injury airplane crash Injured at work? yes23. SIGNATURE W. H. GULLEDGE M. D. or other _____Comdr. (MC) USNAddress _____ Date signed 8/6/46

RECEIVED
AUG 8 1946
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 170-9

CERTIFICATE OF DEATH

Reg. Dist. No. 08315

1. PLACE OF DEATH:

County St. Mary's
 City or town Leonardtown, Md.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?
 Hospital, institution, or street address where death occurred:
St. Mary's Hospital
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Pennsylvania
 City or town Baseville, Pa.
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. —
 (If rural, give LOCATION)
 2.(a) If veteran, name war — V

3. (a) FULL NAME

Rechel S. Stoltyfus
 4. Sex female 5. Color or race white 6.(a) Single, married, widowed, or divorced single

3. (b) Social Security Number

6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) August 1st, 1928
 8. AGE: Years 18 Months 0 Days 17 If less than one day — hrs. — min.

9. Birthplace Baseville, Pa.
 (Town, county, and state)

10. Usual occupation none

11. Industry or business

12. Name John L. Stoltyfus
 13. Birthplace Pennsylvania
 14. Maiden name Unknown
 15. Birthplace Unknown

16. Informant Elmer M. Guade

Address Hughesville, Md.

17. Burial Date thereof 8/20/46
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Myers Cemetery

Location Baseville, Pa.

18. Funeral director Elmer M. Guade

Address Hughesville, Md.

19. 8/18/46 Chandler
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 18, 1946, at 7:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 17, 1946, to August 18, 1946, and that I last saw him or her alive on August 18, 1946.

Immediate cause of death

Respiratory failure
 Due to Penetrating wound of chest

Due to Trauma

Automobile accident, driver
 Other conditions Control failure right leg.
locked left leg.
 (Include pregnancy within 3 months of death)

Major findings of operations Penetrating wound of chest, cont.
fracture right leg. Date of op. 8/17/46

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of August 17, 1946

Where did injury occur? Intersection of Route 5 and Route 6 at Naamans
 (City or town) (County) (State) (Post, Md.)

Injured at home, farm, industry, public place (where?) Public place

Means of injury Automobile accident Injured at work?

23. SIGNATURE Jalen S. Law M.D. M. D. or other

Address Leonardtown, Md. Date signed 8/18/46

F. F. Greenwell Coroner

RECEIVED
AUG 22 1946
BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 159

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County St. Mary'sCity or town Lanham
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 3 hrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Infant Lorne

3. (b) Social Security Number

4. Sex

m

5. Color or race

col

6. (a) Single, married, widowed, or divorced

—

6. (b) Name of husband or wife

7. Birth date of

deceased (mo., day, yr.)

Aug 29 / 46

6. (c) If alive, give age _____ years

8. AGE:

Years

Months

Days

If less than one day

5 hrs.

min.

9. Birthplace

md

(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden name

15. Birthplace

16. Informant

Address

17.

(Burial, cremation, or removal, Which?)

Date thereof

(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19.

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

MEDICAL CERTIFICATION

20. DATE OF DEATH

Aug 30 46 at 49 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Aug 29 46 to Aug 30 46and that I last saw him alive on Aug 30 46

Immediate cause of death

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address

Date signed

STANDARD TELEPHONE & CABLE CO.
RECEIVED

RECEIVED

AUG 31 1946

BUREAU V S

Longman

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (75)

CERTIFICATE OF DEATH

Reg. Dist. No. 08314

1. PLACE OF DEATH:

County St. Mary's CountyCity or town near Oakville, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Unknown County

City or town (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

WHITMORE, Clifford Maynard

3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Male

White

Married

8. (b) Name of husband or wife Darlynne Whitmore

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8-5-198. AGE: Years Months Days If less than one day
27 0 0 hrs. min.9. Birthplace Aberdeen, South Dakota
(Town, county, and state)10. Usual occupation Aviator11. Industry or business U.S. Navy12. Name Unknown

13. Birthplace

14. Maiden name Unknown

15. Birthplace

16. Informant U. S. NavyAddress Patuxent River Md.17. Transportation 8/7/46
(Burial, cremation, or removal. Which?) Date thereof (month) (day) (year)Cemetery or crematory Bookings, South DakotaLocation Bookings, South Dakota18. Funeral director Leonard Brown, Md.Address Hy 4619. 46 Cavalier
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 5 August 1946 at 3:45 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from not attended 19 to 19and that I last saw him alive on not attended 19Immediate cause of death Injuries, Multiple, Extreme. DURATIONDue to Airplane Crash

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide accident Date of 5 Aug. 46Where did injury occur? near Oakville, Maryland
(City or town) (County) (State)Injured at home, farm, industry, public place (where?) airplane crashMeans of injury airplane crash Injured at work? yes23. SIGNATURE J. Warren J. WARREN, Comdr. (MC) USNRUS NAS, Patuxent River, Md. 7 Aug. 46

Address Date signed

REC-11
AUG 9 1946
BUREAU V.S.